san diego dental studio
Dr Tom Bierman | Dr Quan Ma

# PATIENT INFORMATION

Patient's name:_____ Preferred name:_____ Birth date:_____

If minor, parent's name:_____

Home phone:_____ Work phone:_____ Cell phone:_____

Email address:_____ Preferred method of contact:_____

Mailing address:_____ City:_____ State:_____ Zip code:_____

Employer:_____ Occupation:_____

Spouse's name:_____ Spouse's employer:_____ □ Unmarried

Emergency contact name: _____ Emergency contact phone:_____

Who may we thank for referring you to our office?_____

BILLING, CREDIT, AND INSURANCE INFORMATION: □ Not covered by dental insurance

Social Security number:_____ Dental insurance co.: _____ Group number:_____

Covered by spouse's insurance? □ Yes □ No

Spouse's dental insurance company:_____ Group number:_____

Spouse's birth date:_____ Social Security number:_____

## MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check Yes or No)

□ Yes □ No Cancer or tumor
□ Yes □ No Heart ailment or angina
□ Yes □ No Heart murmur, mitral valve prolapse, heart defect
□ Yes □ No Rheumatic fever or rheumatic heart disease
□ Yes □ No Artificial joint or valve
□ Yes □ No High or low blood pressure
□ Yes □ No Pacemaker
□ Yes □ No Tuberculosis or other lung problems
□ Yes □ No Kidney disease
□ Yes □ No Hepatitis or other liver disease
□ Yes □ No Alcoholism
□ Yes □ No Blood transfusion
□ Yes □ No Diabetes
□ Yes □ No Neurologic condition
□ Yes □ No Epilepsy, seizures, or fainting spells
□ Yes □ No Emotional condition
□ Yes □ No Arthritis
□ Yes □ No Herpes or cold sores
□ Yes □ No AIDS or HIV positive
□ Yes □ No Migraine headaches or frequent headaches
□ Yes □ No Anemia or blood disorders
□ Yes □ No Abnormal bleeding after extractions, surgery, or trauma
□ Yes □ No Hayfever or sinus trouble
□ Yes □ No Allergies or hives
□ Yes □ No Asthma
□ Yes □ No Do you snore or have you been told that you snore?
□ Yes □ No Have you been previously diagnosed with sleep apnea?
If yes, do you use a CPAP? □ Yes □ No
□ Yes □ No Do you smoke or use chewing tobacco?

Are you **allergic** to, or have you reacted adversely to any of the following?
(Please check Yes or No)

□ Yes □ No Latex materials
□ Yes □ No Penicillin or other antibiotics
□ Yes □ No Local anesthetics ("Novocain")
□ Yes □ No Codeine or other narcotics
□ Yes □ No Sulfa drugs
□ Yes □ No Barbiturates, sedatives, or sleeping pills
□ Yes □ No Aspirin
Other:_____

Are you taking any of the following? (Please check Yes or No)
□ Yes □ No Aspirin
□ Yes □ No Anticoagulants (blood thinners)
□ Yes □ No Antibiotics or sulfa drugs
□ Yes □ No High blood pressure medicine
□ Yes □ No Antidepressants or tranquilizers
□ Yes □ No Insulin, Orinase, or other diabetes drug
□ Yes □ No Nitroglycerin
□ Yes □ No Cortisone or other steroids
□ Yes □ No Osteoporosis (bone density) medicine
Other:_____

Women: (Please check Yes or No)
□ Yes □ No Are you pregnant?
If yes, expected delivery date is:_____
□ Yes □ No Taking hormones or contraceptives

Name of your physician:_____

Do/did you have any diseases, surgery, or problem not listed above?_____

Please write all medications you are taking:_____

Print name:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of patient, parent, or guardian Date

(Please type your name in the space provided above to electronically sign your name)